		FOR OHF USE					

LL1

2001
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2001)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0009258

Facility Name: Good Samaritan Home

Address: 2130 Harrison Street (Number) Quincy (City) 62301 (Zip Code)

County: Adams

Telephone Number: (217) 223-8717 **Fax #** (217) 223-6015

IDPA ID Number: 370724112001

Date of Initial License for Current Owners: 2/22/1957

Type of Ownership:

x	VOLUNTARY,NON-PROFIT		PROPRIETARY		GOVERNMENTAL		
	x	Charitable Corp.		Individual		State	
		Trust		Partnership		County	
IRS Exemption Code	501 (c) (3)			Corporation		Other	
				"Sub-S" Corp.			
				Limited Liability Co.			
				Trust			
				Other			

In the event there are further questions about this report, please contact:
Name: Michael G. Kaplan **Telephone Number:** (312) 634-3400
Please send copies of desk review and audit adjustments to address on this page

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 10/01/00 to 09/30/01 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider
(Signed) _____ (Date)
(Type or Print Name) _____
(Title) _____

Paid Preparer
(Signed) SEE ACCOUNTANTS' COMPILATION REPORT (Date)
(Print Name and Title) _____
(Firm Name & Address) Altschuler, Melvoin and Glasser LLP, One South Wacker Drive, Suite 800, Chicago, IL 60606
(Telephone) (312) 634-3400 Fax # (312) 634-5518

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 **Phone # (217) 782-1630**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Good Samaritan Home # 0009258 Report Period Beginning: 10/01/00 Ending: 09/30/01

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds N/A

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	46	Skilled (SNF)	46	16,790	1
2		Skilled Pediatric (SNF/PED)			2
3	132	Intermediate (ICF)	132	48,180	3
4		Intermediate/DD			4
5	101	Sheltered Care (SC)	101	36,865	5
6		ICF/DD 16 or Less			6
7	279	TOTALS	279	101,835	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	1,905	2,560	2,604	7,069	8
9	SNF/PED					9
10	ICF	21,649	62,510		84,159	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	23,554	65,070	2,604	91,228	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 89.58%

D. How many bed-hold days during this year were paid by Public Aid? 401 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients. (E.g., day care, "meals on wheels", outpatient therapy)
Outpatient Therapy - Pool Exercise Classes

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [X] NO [ ] Non-allowable costs have been eliminated in Schedule V, Column 7

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [X] NO [ ]

I. On what date did you start providing long term care at this location?
Date started 2/22/57

J. Was the facility purchased or leased after January 1, 1978?
YES [ ] Date NO [x]

K. Was the facility certified for Medicare during the reporting year?
YES [x] NO [ ] If YES, enter number of beds certified 8 and days of care provided 2,604

Medicare Intermediary AdminaStar Federal

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [x] NO [ ]

Tax Year: 09/30/01 Fiscal Year: 09/30/01

* All facilities other than governmental must report on the accrual basis.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Good Samaritan Home # 0009258 Report Period Beginning: 10/01/00 Ending: 09/30/01

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7**	8	9	10	
1	Dietary	680,401	50,815	19,641	750,857		750,857	(4,600)	746,257			1
2	Food Purchase		598,376		598,376		598,376	(10,114)	588,262			2
3	Housekeeping	240,540	41,429	19,442	301,411		301,411	(2,525)	298,886			3
4	Laundry	112,272		23,761	136,033		136,033		136,033			4
5	Heat and Other Utilities			396,140	396,140		396,140		396,140			5
6	Maintenance	240,056	46,796	126,162	413,014		413,014	(13,203)	399,811			6
7	Other (specify):*											7
8	TOTAL General Services	1,273,269	737,416	585,146	2,595,831		2,595,831	(30,442)	2,565,389			8
	B. Health Care and Programs											
9	Medical Director			3,600	3,600		3,600		3,600			9
10	Nursing and Medical Records	3,566,678	218,538	24,140	3,809,356		3,809,356		3,809,356			10
10a	Therapy	153,120	9,284	133,205	295,609		295,609		295,609			10a
11	Activities	118,104	3,800	11,697	133,601		133,601		133,601			11
12	Social Services	143,113	1,076	462	144,651		144,651		144,651			12
13	Nurse Aide Training			2,583	2,583		2,583		2,583			13
14	Program Transportation											14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	3,981,015	232,698	175,687	4,389,400		4,389,400		4,389,400			16
	C. General Administration											
17	Administrative	153,484			153,484		153,484		153,484			17
18	Directors Fees											18
19	Professional Services			55,940	55,940		55,940	(420)	55,520			19
20	Dues, Fees, Subscriptions & Promotions			62,220	62,220		62,220	(431)	61,789			20
21	Clerical & General Office Expenses	289,901	46,680	75,687	412,268		412,268	(8,087)	404,181			21
22	Employee Benefits & Payroll Taxes			1,084,039	1,084,039		1,084,039		1,084,039			22
23	Inservice Training & Education											23
24	Travel and Seminar			15,412	15,412		15,412	(1,954)	13,458			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			44,606	44,606		44,606		44,606			26
27	Other (specify):*											27
28	TOTAL General Administration	443,385	46,680	1,337,904	1,827,969		1,827,969	(10,892)	1,817,077			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	5,697,669	1,016,794	2,098,737	8,813,200		8,813,200	(41,334)	8,771,866			29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.

SEE ACCOUNTANTS' COMPILATION REPORT

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number Good Samaritan Home #0009258 Report Period Beginning: 10/01/00 Ending: 09/30/01

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7**	8	9	10	
30	Depreciation			480,920	480,920		480,920	(2,607)	478,313			30
31	Amortization of Pre-Op. & Org.											31
32	Interest											32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*											36
37	**TOTAL Ownership**			480,920	480,920		480,920	(2,607)	478,313			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		38,955		38,955		38,955		38,955			39
40	Barber and Beauty Shops	50,248	3,574	47	53,869		53,869		53,869			40
41	Coffee and Gift Shops	18,276	33,085		51,361		51,361		51,361			41
42	Provider Participation Fee			97,455	97,455		97,455		97,455			42
43	Other (specify):* Nonallowable costs	60,013		735,399	795,412		795,412	(795,412)				43
44	**TOTAL Special Cost Centers**	128,537	75,614	832,901	1,037,052		1,037,052	(795,412)	241,640			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	5,826,206	1,092,408	3,412,558	10,331,172		10,331,172	(839,353)	9,491,819			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

****See schedule of adjustments attached at end of cost report**

Facility Name & ID Number Good Samaritan Home # 0009258 Report Period Beginning: 10/01/00 Ending: 09/30/01

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(10,114)	2		4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(706)	30		9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(1,818)	43		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties	(8,030)	43		18
19	Entertainment				19
20	Contributions	(3,750)	21		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(7,663)	43		24
25	Fund Raising, Advertising and Promotional				25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule See attach Sch 5A	(807,272)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (839,353)		$	30

OHF USE ONLY									
48		49		50		51		52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)			34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (839,353)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.		X	$		38
39						39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology		X			42
43	Prescription Drugs		X			43
44	Exceptional Care Program		X			44
45	Other-Attach Schedule		X			45
46	Other-Attach Schedule		X			46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

SEE ACCOUNTANTS' COMPILATION REPORT

Good Samaritan Home
0009258
09/30/01

Schedule 5A

VI. ADJUSTMENT DETAIL
NON-ALLOWABLE EXPENSES
LINE 29 - Other

Description	Amount	Schedule V Reference
Out of period legal fees	(420)	19
To disallow Chamber of Commerce dues	(431)	20
To disallow Rotary & Kiwanis Club dues	(1,102)	21
To disallow out of state travel	(1,954)	24
To capitalize dietary software cost	(4,600)	1
To capitalize administration equipment	(2,099)	21
To set prepaid expense for a Maint Contract	(2,748)	6
To set up deferred Maintenance Expense	(12,546)	6
To record deferred Maintenance Expense for year	2,091	6
To disallow radio station expense	(867)	43
To disallow X-Ray expense	(704)	43
To disallow Lab expense	(6,196)	43
To disallow investment consultants	(193,847)	43
To disallow non patient care workshop	(105)	43
To offset guest room income	(1,901)	30
To disallow cottage service income	(2,525)	3
To offset miscellaneous income	(465)	21
To offset discount earned income	(671)	21
To disallow rental property expenses	(7,241)	43
To disallow radio station depreciation	(935)	43
To disallow cottage expenses	(568,006)	43
Total	**(807,272)**	

See Accountants' Compilation Report

Good Samaritan Home

ID# 0009258

Report Period Beginning: 10/01/00

Ending: 09/30/01

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1		$		1
2				2
3				3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	0		49

STATE OF ILLINOIS **Summary A**

Facility Name & ID Number Good Samaritan Home **#** 0009258 **Report Period Beginning:** 10/01/00 **Ending:** 09/30/01

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(10,114)	0	0	0	0	0	0	0	0	0	0	(10,114)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(10,114)	0	0	0	0	0	0	0	0	0	0	(10,114)	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	0	0	0	0	0	0	0	0	0	0	0	19
20	Fees, Subscriptions & Promotions	0	0	0	0	0	0	0	0	0	0	0	0	20
21	Clerical & General Office Expenses	(3,750)	0	0	0	0	0	0	0	0	0	0	(3,750)	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	**TOTAL General Administration**	(3,750)	0	0	0	0	0	0	0	0	0	0	(3,750)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(13,864)	0	0	0	0	0	0	0	0	0	0	(13,864)	29

STATE OF ILLINOIS **Summary B**

Facility Name & ID Number Good Samaritan Home **#** 0009258 **Report Period Beginning:** 10/01/00 **Ending:** 09/30/01

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	(706)	0	0	0	0	0	0	0	0	0	0	(706)	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	0	0	0	0	0	0	0	0	0	0	0	0	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	(706)	0	0	0	0	0	0	0	0	0	0	(706)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	(17,511)	0	0	0	0	0	0	0	0	0	0	(17,511)	43
44	**TOTAL Special Cost Centers**	(17,511)	0	0	0	0	0	0	0	0	0	0	(17,511)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(32,081)	0	0	0	0	0	0	0	0	0	0	(32,081)	45

Facility Name & ID Number Good Samaritan Home # 0009258 Report Period Beginning: 10/01/00 Ending: 09/30/01

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
N/A		N/A		N/A		

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [ ] YES [x] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V			$			$	$	1
2	V				N/A				2
3	V								3
4	V								4
5	V								5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$			$	$ *	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Good Samaritan Home # 0009258 Report Period Beginning: 10/01/00 Ending: 09/30/01

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	N/A								$		1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number Good Samaritan Home # 0009258 Report Period Beginning: 10/01/00 Ending: 09/30/01

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [ ] NO [x]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1		N/A				$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Good Samaritan Home # 0009258 Report Period Beginning: 10/01/00 Ending: 09/30/01

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
		YES	NO				Original	Balance				
	A. Directly Facility Related											
	Long-Term											
1	N/A						$	$			$	1
2												2
3												3
4												4
5												5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related						$	$			$	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$	$			$	15

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

Facility Name & ID Number Good Samaritan Home # 0009258 Report Period Beginning: 10/01/00 Ending: 09/30/01

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2000 report.	***Important***, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.	$	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		$ N/A	2
3. Under or (over) accrual (line 2 minus line 1).		$	3
4. Real Estate Tax accrual used for 2001 report. (Detail and explain your calculation of this accrual on the lines below.)		$	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**		$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For 19 Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**		$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		$	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
	1996	8
	1997	9
	1998	10
	1999	11
	2000	12

	FOR OHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2000	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2000 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2000 real estate tax costs, as well as copies of your real estate tax bills for calendar 2000.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2000 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2001 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, [illegible]

2000 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Good Samaritan Home COUNTY Adams

FACILITY IDPH LICENSE NUMBER 0009258

CONTACT PERSON REGARDING THIS REPORT Judy Graham

TELEPHONE (217) 223-8717 FAX #: (217) 223-6015

A. **Summary of Real Estate Tax Cos**

Enter the tax index number and real estate tax assessed for 2000 on the lines provided below. Enter only the portion of tl cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursir home property which is vacant, rented to other organizations, or used for purposes other than long term care must not l entered in Column D. Do not include cost for any period other than calendar year 200(

	(A) Tax Index Numbe	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.			$	$
2.		N/A	$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$	$

B. **Real Estate Tax Cost Allocation**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not direct used for nursing home services' _____ YES _____ NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing hom (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used

C. **Tax Bills**

Attach a copy of the 2000 tax bills which were listed in Section A to this statement. Be sure to use the 2000 tax bill whic is normally paid during 2001.

Facility Name & ID Number Good Samaritan Home # 0009258 Report Period Beginning: 10/01/00 Ending: 09/30/01

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 169,463 B. General Construction Type: Exterior Brick Frame Steel Number of Stories 2

C. Does the Operating Entity? [x] (a) Own the Facility [ ] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [x] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [ ] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

Residential Cottage Apartments 160 units for 174,278 square feet

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [x] NO
If so, please complete the following:

1. Total Amount Incurred: N/A
2. Number of Years Over Which it is Being Amortized: N/A
3. Current Period Amortization: N/A
4. Dates Incurred: N/A

Nature of Costs: N/A
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Facility	1,219,680	1956-1999	$ 128,278	1
2					2
3	TOTALS	1,219,680		$ 128,278	3

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Good Samaritan Home # 0009258 Report Period Beginning: 10/01/00 Ending: 09/30/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	30			1957	$ 358,309	$	40	$	$	$ 358,309	4
5	75			1962	683,823	17,096	40	17,096		672,439	5
6	99			1973	1,683,761	42,094	40	42,094		1,173,735	6
7	75			1984	1,953,541	48,838	40	48,838		858,748	7
8											8
	Improvement Type**										
9	Building Service Equipment			1973	38,904		20			38,904	9
10	Land Improvements			1974	26,525	43	30	43		26,409	10
11	Building Improvements			1974	89,670	1,012	30	1,012		87,058	11
12	Building Improvements			1975	28,553		20			28,553	12
13	Building Improvements			1976	9,414		20			9,414	13
14	Building Improvements			1977	3,107		20			3,107	14
15	Building Service Equipment			1978	5,714		15			5,714	15
16	Building Improvements			1979	179		20			179	16
17	Building Service Equipment			1979	9,188		Various			9,188	17
18	Building Service Equipment			1980	1,596		Various			1,596	18
19	Building Improvements			1982	151,081	5,276	Various	5,276		102,903	19
20	Building Service Equipment			1982	17,350		Various			17,350	20
21	Building Service Equipment			1983	10,058	503	20	503		9,137	21
22	Land Improvements			1984	49,187		15			49,187	22
23	Building Service Equipment			1984	816,496	17,182	Various	17,182		770,723	23
24	Land Improvements			1985	29,707	1,355	20	1,355		24,058	24
25	Building Improvements			1985	250,935	6,273	40	6,273		102,049	25
26	Building Service Equipment			1985	184,917	8,643	Various	8,643		153,988	26
27	Land Improvements			1986	72,453	3,518	20	3,518		56,736	27
28	Building Improvements			1986	161,531	4,038	40	4,038		61,482	28
29	Building Service Equipment			1986	137,391	6,241	Various	6,241		95,332	29
30	Building Improvements			1987	19,089	500	Various	500		6,964	30
31	Building Service Equipment			1987	21,221	1,061	20	1,061		15,203	31
32	Land Improvements			1988	19,174	891	20	891		12,940	32
33	Building Service Equipment			1988	14,400	697	Various	697		12,831	33
34	Building Improvements			1989	174,123	6,666	Various	6,666		96,923	34
35	Building Service Equipment			1989	6,469	225	Various	225		5,907	35
36	Garage Additions			1990	78,563	2,619	30	2,619		30,552	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

Facility Name & ID Number Good Samaritan Home # 0009258 Report Period Beginning: 10/01/00 Ending: 09/30/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	New Roof - North Wing	1990	$ 43,980	$ 2,199	20	$ 2,199	$	$ 25,105	37
38	Phones	1990	600		10			600	38
39	Hall Renovations	1991	20,616	1,031	20	1,031		10,909	39
40	Building Improvements State Audit Adjustments 10881+30372	1991	511,992	18,442	30	17,066	(1,376)	190,562	40
41	Ceiling/partitions	1991	37,276	1,243	30	1,243		12,840	41
42	Office Entrance	1991	14,768	738	20	738		8,122	42
43	Building Services Equipment State Aduit Adjustment of 359	1991	83,893	3,767	various	3,767		78,172	43
44	Parking Lot	1992	4,257	213	20	213		1,702	44
45	Building Services Equipment	1992	2,706	271	10	271		2,165	45
46	Parking Lot	1992	46,071	2,304	20	2,304		19,772	46
47	Kitchen/Dining Room	1993	310,412	7,760	40	7,760		64,669	47
48	Building Services Equipment	1993	20,910	1,112	various	1,112		15,871	48
49	Parking Lot	1994	87,827	5,855	15	5,855		45,377	49
50	Manhole/Sewer	1994	2,859	191	15	191		1,461	50
51	Sidewalk	1994	7,875	525	15	525		3,719	51
52	West Nursing	1994	66,876	3,344	20	3,344		23,407	52
53	Dining Room	1994	6,990	384	various	384		3,036	53
54	Building Services Equipment	1994	134,323	12,150	various	12,150		92,444	54
55	West Nursing	1995	128,327	6,416	20	6,416		42,241	55
56	West Nursing	1995	3,151	158	20	158		866	56
57	Building Services Equipment	1995	22,482	1,469	various	1,469		13,347	57
58	Gas Line	1996	3,062	153	20	153		842	58
59	Gutters	1996	10,817	541	20	541		2,975	59
60	Eber Wing Improvements	1996	20,335	1,017	20	1,017		5,592	60
61	Roof	1996	9,016	451	20	451		2,479	61
62	Roof - Anna Brown Wing	1996	70,800	3,540	20	3,540		17,405	62
63	Building Services Equipment	1996	46,663	2,950	various	2,950		16,227	63
64	Lights/Front Land Improvements	1997	5,360	357	15	357		1,697	64
65	Walls/Floor - Anna Brown Wing	1997	41,780	2,089	20	2,089		9,401	65
66	Freezer Floor	1997	4,394	258	17	258		1,292	66
67	Roof-Anna Brown Wing	1997	48,740	1,250	39	1,250		4,816	67
68	Sprinkling System	1997	3,354	336	10	336		1,174	68
69	Tamper Detectors	1997	2,818	282	10	282		986	69
70	TOTAL (lines 4 thru 69)		$ 8,931,759	$ 257,567		$ 256,191	$ (1,376)	$ 5,618,891	70

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Good Samaritan Home # 0009258 Report Period Beginning: 10/01/00 Ending: 09/30/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		$ 8,931,759	$ 257,567		$ 256,191	$ (1,376)	$ 5,618,891	1
2	Compressor - Eber	1997	2,039	136	15	136		589	2
3	Compressor - East	1997	11,808	787	15	787		3,346	3
4	Sprinkler System	1997	102,875	5,144	20	5,144		21,004	4
5	Air Exchange -Pool Area State Audit adjustment 480	1997	8,092	572	15	572		2,429	5
6	Roof- Kitchen/Dinning	1998	45,550	1,168	39	1,168		4,376	6
7	Elevator Doors Dietary	1998	1,095	110	10	110		383	7
8	Underground Tanks	1998	23,092	2,309	10	2,309		8,082	8
9	Remodeling -Anna Brow Wing Walls, Celing, Floors,Lights	1999	199,131	4,978	39	4,978		10,994	9
10	Remodeling -Anna Brow Wing - Duct Detectors	1999	1,444	289	5	289		722	10
11	Remodeling -Anna Brow Wing - Carpeting	1999	2,966	297	10	297		741	11
12	Remodeling -Anna Brow Wing - Fire Damper	1999	21,915	548	39	548		1,301	12
13	Chapel Roof	1999	21,515	538	39	538		1,546	13
14	Fire Damper Alarm	1999	5,490	1,098	5	1,098		2,745	14
15	Eber Parking Lot Lights	1999	5,495	366	15	366		916	15
16	Lawn	1999	661	132	5	132		330	16
17	Stainless Steel D/W Exhaust	1999	1,659	166	10	166		415	17
18	Wiring Chapel Roof	1999	332	33	10	33		83	18
19	HVAC Chapel	1999	23,760	1,584	15	1,584		3,960	19
20	Code Alert System	1999	61,985	12,397	5	12,397		30,992	20
21	Elevator Upgrade A/B East	1999	22,556	2,256	10	2,256		5,639	21
22	Elevator Upgrade - Special Care	1999	5,970	597	10	597		1,493	22
23	Fire Protection A/B	1999	4,500	450	10	450		1,125	23
24	Condensor Unit	1999	22,945	1,530	15	1,530		3,824	24
25	Fire Proctection Pool Area	1999	776	78	10	78		194	25
26	Damper Duct Work	1999	5,602	373	15	373		934	26
27	Lighting- Special Care	1999	2,075	138	15	138		346	27
28	Chapel Remodeling - Fire Damper	2000	3,196	213	15	213		320	28
29	Chapel Remodeling - Sign	2000	77	15	5	15		23	29
30	Chapel Remodeling - Painting	2000	4,751	119	39	119		124	30
31	Chapel Remodeling - Carpeting	2000	3,073	205	15	205		307	31
32	Chapel Remodeling - Unity & Pews	2000	14,760	369	39	369		384	32
33	Kitchen Remodeling - Hood	2000	2,511	167	15	167		251	33
34	TOTAL (lines 1 thru 33)		$ 9,565,455	$ 296,729		$ 295,353	$ (1,376)	$ 5,728,809	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Good Samaritan Home # 0009258 Report Period Beginning: 10/01/00 Ending: 09/30/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		$ 9,565,455	$ 296,729		$ 295,353	$ (1,376)	$ 5,728,809	1
2	Kitchen Remodeling - Sky Roof Flashing	2000	3,086	206	15	206		309	2
3	Kitchen Remodeling - Sidewalls	2000	3,485	232	15	232		349	3
4	Kitchen Remodeling - Galvanized Wall Divider	2000	2,601	173	15	173		260	4
5	East Nursing Remodeling - Walls, Ceilings, Floors	2000	26,757	669	39	669		864	5
6	Eber Wing Smoke Damper	2000	16,485	1,099	15	1,099		1,649	6
7	Special Care Lighting	2000	14,290	953	15	953		1,429	7
8	HVAC Rehab Eber Wing	2000	305,419	20,361	15	20,361		30,542	8
9	Groundkeeper	2000	5,298	757	7	757		1,135	9
10	3 Ton Rooftop Unit A/C West Dining	2000	2,776	185	15	185		278	10
11	Telephone Unit	2000	323	46	7	46		69	11
12	Elevator Up Grade East Wing	2000	12,776	852	15	852		1,278	12
13	Superior Boiler Burner Up Grade	2000	1,101	73	15	73		110	13
14	Entrance Codelock Special Care	2000	1,848	123	15	123		185	14
15	Life Safety Code Sprinkler Drains	2000	7,000	467	15	467		700	15
16	Land Improvement New Sidewalk	2000	1,200	30	20	30		30	16
17	Renovation of East nursing Wing	2001	369,213	1,923	39	1,923		1,923	17
18	Exterior Painting	2001	14,347	478	15	478		478	18
19	Painting Kitchen	2001	2,550	85	15	85		85	19
20	Chapel Renovation	2000	2,001	44	39	44		44	20
21	Kitchen Electrical Work	2000	611	20	15	20		20	21
22	HVAC Rehab Eber Wing	2000	5,584	186	15	186		186	22
23	Sprinklers	2000	4,151	138	15	138		138	23
24	Wet Chemical Fire Suppressor Work	2000	3,695	123	15	123		123	24
25	Electrical Work	2001	1,609	54	15	54		54	25
26	Smoke/ Fire Damper East, South and Eber	2001	50,735	1,691	15	1,691		1,691	26
27	Air Compressor Anna Brown Wing	2001	10,911	364		364		364	27
28	Guest Room Income Offset					(1,901)	(1,901)		28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 10,435,307	$ 328,061		$ 324,784	$ (3,277)	$ 5,773,102	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Good Samaritan Home # 0009258 Report Period Beginning: 10/01/00 Ending: 09/30/01

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 885,944	$ 110,195	$ 110,195	$	20-3 yrs	$ 540,089	71
72	Current Year Purchases	123,241	9,104	9,774	670	10-5 yrs	9,774	72
73	Fully Depreciated Assets	1,195,314	13,182	13,182		20-3 yrs	1,195,314	73
74								74
75	TOTALS	$ 2,204,499	$ 132,481	$ 133,151	$ 670		$ 1,745,177	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	Resident	Various	Various	$ 97,782	$ 16,004	$ 16,004	$	3-5 yrs	$ 61,357	76
77	Maintenance	Various	Various	73,691	4,374	4,374		3-5 yrs	66,030	77
78	Maintenance	Various	Various	1,219				3	1,219	78
79										79
80	TOTALS			$ 172,692	$ 20,378	$ 20,378	$		$ 128,606	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount		
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 12,940,776	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 480,920	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 478,313	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ (2,607)	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 7,646,885	85	

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86	Cottage Land	$ 76,532	$	$	86
87	Rental Property Land	75,730			87
88	Cottage Fixed Assets	7,978,507	269,441	3,842,922	88
89	Rental Property Fixed Assets	219,235	7,241	24,466	89
90	Radio Station	14,032	935	13,094	90
91	TOTALS	$ 8,364,036	$ 277,617	$ 3,880,482	91

G. Construction-in-Progress

	Description	Cost	
92	Building Improvement	$ 341,697	92
93			93
94			94
95		$ 341,697	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

Facility Name & ID Number Good Samaritan Home # 0009258 Report Period Beginning: 10/01/00 Ending: 09/30/01

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4? If NO, see instructions. [ ] YES [x] NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:		N/A		$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34. N/A
This amount was calculated by dividing the total amount to be amortized N/A
by the length of the lease N/A .

9. Option to Buy: [ ] YES [x] NO Terms: N/A *

10. Effective dates of current rental agreement:
Beginning N/A
Ending N/A

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2002	$ N/A
13.	/2003	$ N/A
14.	/2004	$ N/A

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? [ ] YES [x] NO

16. Rental Amount for movable equipment: $ N/A Description: N/A
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$ N/A	$	17
18					18
19					19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number Good Samaritan Home # 0009258 Report Period Beginning: 10/01/00 Ending: 09/30/01

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD? [x] YES [ ] NO

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:

IN-HOUSE PROGRAM	[ ]
IN OTHER FACILITY	[ ]
COMMUNITY COLLEGE	[x]
HOURS PER AIDE	40

3. CLINICAL PORTION:

IN-HOUSE PROGRAM	[ ]
IN OTHER FACILITY	[x]
HOURS PER AIDE	80

B. EXPENSES

ALLOCATION OF COSTS (d)

		1 Facility Drop-outs	2 Facility Completed	3 Contract	4 Total
1	Community College Tuition	$	$ 1,988	$	$ 1,988
2	Books and Supplies		595		595
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	$	$ 2,583	$	$ 2,583
10	SUM OF line 9, col. 1 and 2 (e)	$ 2,583			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	5
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	5

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Good Samaritan Home # 0009258 Report Period Beginning: 10/01/00 Ending: 09/30/01

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

		1	2		3	4		5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service		Staff Cost	Outside Practitioner (other than consultant) Units		Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	L. 10a C1, 2,3	2176	hrs	$ 45,650	706	$	34,098	$ 5,561	2,882	$ 85,309	1
2	Licensed Speech and Language Development Therapist	L. 10a C 3		hrs		436		22,519		436	22,519	2
3	Licensed Recreational Therapist			hrs								3
4	Licensed Physical Therapist	L. 10a C 1,2,3	4607	hrs	107,470	1,840		76,344	3,723	6,447	187,537	4
5	Physician Care			visits								5
6	Dental Care	L.10 C 2, 3		visits				2,400	717		3,117	6
7	Work Related Program			hrs								7
8	Habilitation			hrs								8
9	Pharmacy	L 39 C 2		# of prescrpts					38,955		38,955	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)			hrs								10
11	Academic Education			hrs								11
12	Exceptional Care Program											12
13	Other (specify):											13
14	TOTAL				$ 153,120	2,982	$	135,361	$ 48,956	9,765	$ 337,437	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

SEE ACCOUNTANTS' COMPILATION REPORT

STATE OF ILLINOIS

Facility Name & ID Number Good Samaritan Home # 0009258 **Report Period Beginning:** 10/01/00 **Ending:** 09/30/01

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 09/30/01 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 58,963	$ 58,963	1
2	Cash-Patient Deposits	28,263	28,263	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance none)	705,553	705,553	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments	1,254,690	1,254,690	5
6	Prepaid Insurance	90,963	90,963	6
7	Other Prepaid Expenses	1,319	4,067	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 2,139,751	$ 2,142,499	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments	23,117,299	23,117,299	12
13	Land	128,278	128,278	13
14	Buildings, at Historical Cost	10,686,019	10,435,307	14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	2,370,492	2,377,191	16
17	Accumulated Depreciation (book methods)	(7,854,835)	(7,646,885)	17
18	Deferred Charges		10,455	18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (spe CIP	341,697	341,697	22
23	Other(specify): Cottage & Rental Property	4,483,554	4,483,554	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 33,272,504	$ 33,246,896	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 35,412,255	$ 35,389,395	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 187,282	$ 187,282	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	28,263	28,263	28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	572,278	572,278	30
31	Accrued Taxes Payable (excluding real estate taxes)	18,448	18,448	31
32	Accrued Real Estate Taxes(Sch.IX-B)	81,379		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See Attached Sch 17C	71,437	71,437	36
37	Prepaid Residents Rent	1,097,729	1,097,729	37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 2,056,816	$ 1,975,437	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 2,056,816	$ 1,975,437	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 33,355,439	$ 33,413,958	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 35,412,255	$ 35,389,395	48

SEE ACCOUNTANTS' COMPILATION REPORT

***(See instructions.)**

Good Samaritan Home
0009258
9/30/2001

Schedule 17C

XV. BALANCE SHEET - Unrestricted Operating Fund.
C. Current Liabilities

Other Current Liabilities (specify):	Operating	After Consolidation
Accrued United Way	246	246
Accrued Miscellaneous Payable Deduction	713	713
Employee Assist Fund Withheld	5,663	5,663
Benevolent Fund Payable	381	381
Flower Fund Payable	(232)	(232)
Ceramics Payable	1,566	1,566
Application Fee Payable	31,230	31,230
Medicare Liability	13,017	13,017
F.W. Education Cost Payable	18,853	18,853
Total Line 36 - Other Current Liabilities(specify):	**71,437**	**71,437**

See Accountants' Compilation Report

Facility Name & ID Number Good Samaritan Home # 0009258 Report Period Beginning: 10/01/00 Ending: 09/30/01

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 38,726,883	1
2	Restatements (describe):		2
3	Rounding	(3)	3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 38,726,880	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(5,371,441)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ (5,371,441)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 33,355,439	24 *

Operating entity only

*** This must agree with page 17, line 47.**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Good Samaritan Home # 0009258 Report Period Beginning: 10/01/00 Ending: 09/30/01

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 7,623,405	1
2	Discounts and Allowances for all Levels	(604,911)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 7,018,494	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	561,426	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 561,426	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop	34,910	12
13	Barber and Beauty Care	53,143	13
14	Non-Patient Meals	10,114	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	47,478	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	48,986	19
20	Radiology and X-Ray	1,009	20
21	Other Medical Services	34,086	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 229,726	23
	D. Non-Operating Revenue		
24	Contributions	247,792	24
25	Interest and Other Investment Income***	(4,231,699)	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ (3,983,907)	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See Attach Schedule 19E	18,402	28
28a	Cottage and Reantal Property Income	1,115,590	28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 1,133,992	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 4,959,731	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	2,595,831	31
32	Health Care	4,389,400	32
33	General Administration	1,827,969	33
	B. Capital Expense		
34	Ownership	480,920	34
	C. Ancillary Expense		
35	Special Cost Centers	939,597	35
36	Provider Participation Fee	97,455	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 10,331,172	40
41	**Income before Income Taxes (line 30 minus line 40)****	(5,371,441)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (5,371,441)	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? yes If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation. SEE ACCOUNTANTS' COMPILATION REPORT**

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Good Samaritan Home
0009258
9/30/2001

Schedule 19E

XVII. INCOME STATEMENT
Revenue

E. Other Revenue (specify):	Amount
Miscellaneous Income	465
Discount Earned Income	671
Guest Room Income	1,901
Van Transportation	7,440
Cottage Services Income	2,525
Application Fee Income	5,400
Total Line 28 - Other Revenue (specify):	**18,402**

See Accountants' Compilation Report

Facility Name & ID Number Good Samaritan Home # 0009258 Report Period Beginning: 10/01/00 Ending: 09/30/01

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,886	2,080	$ 52,048	$ 25.02	1
2	Assistant Director of Nursing	2,084	2,360	47,164	19.98	2
3	Registered Nurses	27,664	29,703	472,429	15.91	3
4	Licensed Practical Nurses	66,274	71,626	920,553	12.85	4
5	Nurse Aides & Orderlies	170,259	184,520	1,803,573	9.77	5
6	Nurse Aide Trainees					6
7	Licensed Therapist	6,029	6,783	153,120	22.57	7
8	Rehab/Therapy Aides	13,388	14,861	148,936	10.02	8
9	Activity Director	1,928	2,080	21,262	10.22	9
10	Activity Assistants	11,970	12,924	96,842	7.49	10
11	Social Service Workers	15,316	16,702	143,113	8.57	11
12	Dietician					12
13	Food Service Supervisor	7,301	8,064	103,992	12.90	13
14	Head Cook	6,385	6,845	69,630	10.17	14
15	Cook Helpers/Assistants	46,077	50,097	401,285	8.01	15
16	Dishwashers	12,285	13,520	105,494	7.80	16
17	Maintenance Workers	22,214	24,763	240,056	9.69	17
18	Housekeepers	26,789	29,377	240,540	8.19	18
19	Laundry	11,999	13,167	112,272	8.53	19
20	Administrator	1,955	2,080	86,890	41.77	20
21	Assistant Administrator	1,916	2,080	66,594	32.02	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	22,858	24,879	289,901	11.65	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	1,972	2,212	31,340	14.17	31
32	Other Health Ca Sch 20A	9,399	10,551	90,635	8.59	32
33	Other(specify) Sch 20A	12,530	13,812	128,537	9.31	33
34	TOTAL (lines 1 - 33)	500,478	545,086	$ 5,826,206 *	$ 10.69	34

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	453	$ 13,139	L 1 C 3	35
36	Medical Director	Monthly	3,600	L 9 C 3	36
37	Medical Records Consultant	Monthly	3,359	L 10 C 3	37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	10,044	L 10 C 3	39
40	Physical Therapy Consultant	2	130	L 10a C 3	40
41	Occupational Therapy Consultant	1	65	L 10a C 3	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant	1	49	L 10a C 3	43
44	Activity Consultant	69	3,792	L 11 C 3	44
45	Social Service Consultant	8	462	L 12 C 3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	534	$ 34,640		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$		50
51	Licensed Practical Nurses				51
52	Nurse Aides		N/A		52
53	TOTAL (lines 50 - 52)		$		53

SEE ACCOUNTANTS' COMPILATION REPORT

* This total must agree with page 4, column 1, line 45.

** See instructions.

Good Samaritan Home
0009258
9/30/2001

Schedule 20A

XVIII. STAFFING AND SALARY COSTS
LINE 32 - Other (Health Care specify)

	# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage
Nursing Secretary	7,428	8,071	$ 69,646	8.63
Medical Supply Clerk	1,971	2,480	20,989	8.46
Total Line 31 - Other	**9,399**	**10,551**	**$ 90,635**	**$ 8.59**

XVIII. STAFFING AND SALARY COSTS
LINE 33 - Other (specify)

	# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage
Maintenance Cottages	5,553	6,191	$ 60,013	9.69
Beauty Shop	4,570	5,028	50,248	9.99
General Store	2,407	2,593	18,276	7.05
Total Line 31 - Other	**12,530**	**13,812**	**$ 128,537**	**$ 9.31**

See Accountants' Compilation Report

Facility Name & ID Number Good Samaritan Home # 0009258 Report Period Beginning: 10/01/00 Ending: 09/30/01

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Michael Duffy	Administrator	0%	$ 86,890
Judy Graham	Asst Admin.	0%	66,594
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			$ 153,484

B. Administrative - Other

Description	Amount
	$
N/A	
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)	$

C. Professional Services

Vendor/Payee	Type	Amount
Keyl Royster Voelker & Allen	Legal	$ 6,071
Schmiedeskamp, Robertson		
Neu & Mitchell	Legal	12,435
Altschuler, Melvion and		
Glasser LLP	Accounting	8,577
American Express Tax and		
Business Services	Accounting	3,760
Computerland	Computer	2,594
Levi,Ray & Shcup	Computer	975
Systematic Management Sys.	Medicare Consulting	1,269
Wade Stables PC	Accounting	16,950
Architechnics, Inc	Administrative Consulting	3,309
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed $2500 attach copy of invoices.)		$ 55,940

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 113,461
Unemployment Compensation Insurance	1,705
FICA Taxes	424,129
Employee Health Insurance	377,925
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Employee Tuition	1,352
Pension Plan	135,534
Employee Medical	9,834
Life Insurance	2,234
Employee Recognition	17,865
TOTAL (agree to Schedule V, line 22, col.8)	$ 1,084,039

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
N/A		
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	37,579
Health Care Worker Background Check	
(Indicate # of checks performed 47)	564
Life Services Network	14,855
Council for Health and Human Services	6,318
Various Dues	2,191
Various License	200
Various Fees	82
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 61,789

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	
See attached schedule	13,458
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 13,458

* Attach copy of IMRF notifications

**See instructions.

Good Samaritan Home
0009258
9/30/2001

Schedule 21A

XIX. SUPPORT SCHEDULE
C. Professional Services

Total (agree to Schedule V, line 19, column 3)	55,940
Out of period Legal bill	(420)
Total (agree to Schedule V, line 19, column 8)	55,520

See Accountants' Compilation Report

Facility Name & ID Number Good Samaritan Home # 0009258 Report Period Beginning: 10/01/00 Ending: 09/30/01

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY1998	FY1999	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005	FY2006
1	Elevator Repairs	Jan 2001	$ 6,737	3	$	$	$	$ 1,123	$ 2,246	$ 2,246	$ 1,122	$	$
2	Water Heater Repair	Dec 2000	1,311	3				218	437	437	219		
3	Kitchen Garbage Disp.	Apr 2001	4,498	3				750	1,499	1,499	750		
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$ 12,546		$	$	$	$ 2,091	$ 4,182	$ 4,182	$ 2,091	$	$

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Good Samaritan Home # 0009258 Report Period Beginning: 10/01/00 Ending: 09/30/01

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **No**

(2) Are there any dues to nursing home associations included on the cost report? **Yes**
If YES, give association name and amount. **Life Services Network $14,855 CHHS $6,318**

(3) Did the nursing home make political contributions or payments to a political action organization? **No** If YES, have these costs been properly adjusted out of the cost report? **N/A**

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **No** If YES, what is the capacity? **N/A**

(5) Have you properly capitalized all major repairs and equipment purchases? **Yes**
What was the average life used for new equipment added during this period? **6.5 yrs**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **69,968** Line **10**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **Yes** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **No**
If YES, give effective date of lease. **N/A**

(9) Are you presently operating under a sublease agreement? ____ YES **x** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES ____ NO **x** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.
N/A

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. $ **97,455**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **No** If YES, attach an explanation of the allocation.

SEE ACCOUNTANTS' COMPILATION REPORT

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **N/A**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **Yes** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **0** Has any meal income been offset against related costs? **Yes** Indicate the amount. $ **10,114**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **Yes**
If YES, attach a complete explanation. Within fifty miles of Illinios
b. Do you have a separate contract with the Department to provide medical transportation for residents? **No** If YES, please indicate the amount of income earned from such a program during this reporting period. $ **N/A**
c. What percent of all travel expense relates to transportation of nurses and patients? **N/A**
d. Have vehicle usage logs been maintained? **Yes**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **Yes**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **N/A**
g. Does the facility transport residents to and from day training? N/A
Indicate the amount of income earned from providing such transportation during this reporting period. $ **N/A**

(17) Has an audit been performed by an independent certified public accounting firm? **Yes**
Firm Name: **Wade Stables P. C.** The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? **Yes** If no, please explain. ____

(18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? **Yes**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? **Yes**
Attach invoices and a summary of services for all architect and appraisal fees.

	Salaries	Supplies	Other	Total	Reclass-ifications	Reclassified Total	Adjustments	Adjusted Total
1. Dietary	680,401	50,815	19,641	750,857	0	750,857	-4,600	746,257
2. Food Purchase	0	598,376	0	598,376	0	598,376	-10,114	588,262
3. Housekeeping	240,540	41,429	19,442	301,411	0	301,411	-2,525	298,886
4. Laundry	112,272	0	23,761	136,033	0	136,033	0	136,033
5. Heat and Other Utilities	0	0	396,140	396,140	0	396,140	0	396,140
6. Maintenance	240,056	46,796	126,162	413,014	0	413,014	-13,203	399,811
7. Other (specify)*	0	0	0	0	0	0	0	0
8. Total General Services	1,273,269	737,416	585,146	2,595,831	0	2,595,831	-30,442	2,565,389
9. Medical Director	0	0	3,600	3,600	0	3,600	0	3,600
10. Nursing & Medical Records	3,566,678	218,538	24,140	3,809,356	0	3,809,356	0	3,809,356
10a. Therapy	153,120	9,284	133,205	295,609	0	295,609	0	295,609
11. Activities	118,104	3,800	11,697	133,601	0	133,601	0	133,601
12. Social Services	143,113	1,076	462	144,651	0	144,651	0	144,651
13. Nurse Aide Training	0	0	2,583	2,583	0	2,583	0	2,583
14. Program Transportation	0	0	0	0	0	0	0	0
15. Other (specify)*	0	0	0	0	0	0	0	0
16. Total Health Care & Programs	3,981,015	232,698	175,687	4,389,400	0	4,389,400	0	4,389,400
17. Administrative	153,484	0	0	153,484	0	153,484	0	153,484
18. Directors Fees	0	0	0	0	0	0	0	0
19. Professional Services	0	0	55,940	55,940	0	55,940	-420	55,520
20. Fees, Subscriptions & Promotion	0	0	62,220	62,220	0	62,220	-431	61,789
21. Clerical & General Office	289,901	46,680	75,687	412,268	0	412,268	-8,087	404,181
22. Employee Benefits & Payroll	0	0	1,084,039	1,084,039	0	1,084,039	0	1,084,039
23. Inservice Training & Education	0	0	0	0	0	0	0	0
24. Travel and Seminar	0	0	15,412	15,412	0	15,412	-1,954	13,458
25. Other Admin. Staff Trans	0	0	0	0	0	0	0	0
26. Insurance-Prop.Liab.Malpractice	0	0	44,606	44,606	0	44,606	0	44,606
27. Other (specify)*	0	0	0	0	0	0	0	0
28. Total General Adminis	443,385	46,680	1,337,904	1,827,969	0	1,827,969	-10,892	1,817,077
29. Total General Administrative	5,697,669	1,016,794	2,098,737	8,813,200	0	8,813,200	-41,334	8,771,866
30. Depreciation	0	0	480,920	480,920	0	480,920	-2,607	478,313
31. Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0
32. Interest	0	0	0	0	0	0	0	0
33. Real Estate	0	0	0	0	0	0	0	0
34. Rent - Facility & Grounds	0	0	0	0	0	0	0	0
35. Rent - Equipment & Vehicles	0	0	0	0	0	0	0	0
36. Other (specify):*	0	0	0	0	0	0	0	0
37. Total Ownership	0	0	480,920	480,920	0	480,920	-2,607	478,313
38. Medically Necessary T	0	0	0	0	0	0	0	0
39. Ancillary Service Cent	0	38,955	0	38,955	0	38,955	0	38,955
40. Barber and Beauty Shop	50,248	3,574	47	53,869	0	53,869	0	53,869
41. Coffee and Gift Shops	18,276	33,085	0	51,361	0	51,361	0	51,361
42	0	0	97,455	97,455	0	97,455	0	97,455
43. Other (specify):*	60,013	0	735,399	795,412	0	795,412	-795,412	0
44. Total Special Cost Ce	128,537	75,614	832,901	1,037,052	0	1,037,052	-795,412	241,640
45. Grand Total	5,826,206	1,092,408	3,412,558	10,331,172	0	10,331,172	-839,353	9,491,819

	Operating	After Consolidation
General Service Cost Center		
1. Cash on hand and in banks	58,963	58,963
2. Cash - Patient Deposits	28,263	28,263
3. Accounts & Notes Recievable	705,553	705,553
4. Supply Inventory	0	0
5. Short-Term Investments	1,254,690	1,254,690
6. Prepaid Insurance	90,963	90,963
7. Other Prepaid Expenses	1,319	4,067
8. Accounts Receivable-Owner/Related Party	0	0
9. Other (specify):	0	0
10. Total current assets	2,139,751	2,142,499
LONG TERM ASSETS		
11. Long-Term Notes Receivable	0	0
12. Long-Term Investments	23,117,299	23,117,299
13. Land	128,278	128,278
14. Buildings, at Historical Cost	10,686,019	10,435,307
15. Leasehold Improvements, Historical Cost	0	0
16. Equipment, at Historical Cost	2,370,492	2,377,191
17. Accumulated Depreciation (book methods)	-7,854,835	-7,646,885
18. Deferred Charges	0	10,455
19. Organization & Pre-Operating Costs	0	0
20. Accum Amort - Org/Pre-Op Costs	0	0
21. Restricted Funds	0	0
22. Other Long-Term Assets (specify):	341,697	341,697
23. other (specify):	4,483,554	4,483,554
24. Total Long-Term Assets	33,272,504	33,246,896
25. Total Assets	35,412,255	35,389,395
CURRENT LIABILITIES		
26. Accounts Payable	187,282	187,282
27. Officer's Accounts Payable	0	0
28. Accounts Payable-Patients Deposits	28,263	28,263
29. Short-Term Notes Payable	0	0
30. Accrued Salaries Payable	572,278	572,278
31. Accrued Taxes Payable	18,448	18,448
32. Accrued Real Estate Taxes	81,379	0
33. Accrued Interest Payable	0	0
34. Deferred Compensation	0	0
35. Federal and State Income Taxes	0	0
36. Other Current Liabilities (specify):	71,437	71,437
37. Other Current Liabilities (specify):	1,097,729	1,097,729
38. Total Current Liabilities	2,056,816	1,975,437
LONG TERM LIABILITES		
39.Long-Term Notes Payable	0	0
40.Mortgage Payable	0	0
41.Bonds Payable	0	0
42.Deferred Compensation	0	0
43.Other Long-Term Liabilities (specify):	0	0
44.Other Long-Term Liabilities (specify):	0	0
45.Total Long-Term Liabilities	0	0
46.Total Liabilities	2,056,816	1,975,437
47.Total Equity	33,355,439	33,413,958
48.Total Liabilities and Equity	35,412,255	35,389,395

	Balance per Medicaid Trial Balance
1. Gross Revenue - All levels of Care	7,623,405
2. Discounts and Allowances for all Levels	-604,911
Subtotal - Inpatient Care	7,018,494
4. Day Care	0
5. Other Care for Outpatients	0
6. Therapy	561,426
7. Oxygen	0
Subtotal - Anciliary Revenue	561,426
9. Payments for Education	0
10. Other Governmental Grants	0
11. Nurses Aide Training Reimbursements	0
12. Gift and Coffee Shop	34,910
13. Barber and Beauty Care	53,143
14. Non-Patient Meals	10,114
15. Telephone, Television, and Radio	0
16. Rental of Facility Space	0
17. Sale of Drugs	47,478
18. Sale of Supplies to Non-Patients	0
19. Laboratory	48,986
20. Radiologyand X-Ray	1,009
21. Other Medical Services	34,086
22. Laundry	0
Subtotal - Other Operating Revenue	229,726
24. Contributions	247,792
25. Interest and Other Investments Income	-4,231,699
Subtotal - Non-Operating Revenue	-3,983,907
27. Other Revenue (specify):	18,402
28. Other Revenue (specify):	1,115,590
Subtotal - Other Revenue	1,133,992
30. Total Revenue	4,959,731
31. General Services	680,120
32. Health Care	1,154,988
33. General Administration	668,561
34. Ownership	144,710
35. Special Cost Centers	60,174
35. Provider Participation Fee	41,063
37. Other	0
40. Total Expenses	2,749,616
41. Income Before Income Taxes	2,210,115
42. Income Taxes	0
43. Net Income or Loss for the Year	2,210,115

Page

Attachment of Real Estate Bill and fill out form

P12 does not show totals, it carries to P12a, therefore P12a must always be attached

The bottom right side of page under **, you must write in any comments

RECONCILIATION REPORT **Good Samaritan Home** **02:48 PM** **11/07/05**

ITEM	Value 1	Cond.	Value 2	Difference	RESULTS	COMPARE CEL	SUB-SCHED.	LINE NO.	COL. NO.	WITH CELL	SUB-SCHED.	LINE NO.	COL. NO.
Adjustment Detail	-839,353	equal to	-839,353	0	O.K.	Pg5 Z22	B.	37	1	Pg4 K29	N/A	45	7
Interest Expense	0	equal to	0	0	O.K.	Pg9 P34	A.	15	10	Pg4 L13	N/A	32	8
Real Estate Tax Expenses	0	equal to	0	0	O.K.	Pg10 W24	B.	5	N/A	Pg4 L14	N/A	33	8
Amortization exp. Pre-opening & org.	N/A	equal to	0	#VALUE!	#VALUE!	Pg11 I33	E.	3	N/A	Pg4 L12	N/A	31	8
Ownership Costs-Depreciation	478,313	equal to	478,313	0	O.K.	Pg13 Y28	E.	49	2	Pg4 L11	N/A	30	8
Rental Costs A	0	equal to	0	0	O.K.	Pg14 L20+N22	A.	7 + 8	4+N/A	Pg4 L15	N/A	34	8
Rental Costs B	0	equal to	0	0	O.K.	Pg14 J30+N40	B.+ C.	16+21	N/A+4	Pg4 L16	N/A	35	8
Nurse Aid Training Prog.	2,583	equal to	2,583	0	O.K.	Pg15 L36	B.	10	1	Pg3 L23	N/A	13	8
Special Serv.- Staff Wages	153,120	equal to		0	O.K.	Pg16 N32	N/A	14	3	Pg4 E22	N/A	39	1
Therapy Services	295,609	equal to	295,609	0	O.K.	Pg16 Z12+Z14..	N/A;B	1-4;40-43	8;2	Pg3 H20	N/A	1Oa	4
Special Serv.- Supplies	48,956	equal to	48,239	717	FAILED	Pg16 V32	N/A	14	6	Pg4 F22 + Pg 3	N/A	39,10a	2
Income Stat. General Serv.	2,595,831	equal to	2,595,831	0	O.K.	Pg19 P11	N/A	31	2	Pg3 H16	N/A	8	4
Income Stat. Health Care	4,389,400	equal to	4,389,400	0	O.K.	Pg19 P12	N/A	32	2	Pg3 H26	N/A	16	4
Income Stat. Admininstation	1,827,969	equal to	1,827,969	0	O.K.	Pg19 P13	N/A	33	2	Pg3 H39	N/A	28	4
Income Stat. Ownership	480,920	equal to	480,920	0	O.K.	Pg19 P15	N/A	34	2	Pg4 H18	N/A	37	4
Income Stat. Special Cost Ctr	939,597	equal to	939,597	0	O.K.	Pg19 P17	N/A	35	2	Pg4 H21..H24+H	N/A	38to41+43	4
Income Stat. Prov. Partic.	97,455	equal to	97,455	0	O.K.	Pg19 P18	N/A	36	2	Pg4 H25	N/A	42	4
Staff- Nursing	3,566,678	equal to	3,566,678	0	O.K.	Pg20 K11..K15+	A.	1-5,24,25,27-30	3	Pg3 E19	N/A	10	1
Staff- Nurse aide Training	0	< or = to		0	O.K.	Pg20 K16	A.	6	3	Pg3 E23	N/A	13	1
Staff-Licensed Therapist	153,120	equal to		0	O.K.	Pg20 K17	A.	7	3	Pg4 E22	N/A	39	1
Staff- Activities	118,104	equal to	118,104	0	O.K.	Pg20 K19+K20	A.	9+10	3	Pg3 E21	N/A	11	1
Staff- Social Serv. Workers	143,113	equal to	143,113	0	O.K.	Pg20 K21	A.	11	3	Pg3 E22	N/A	12	1
Staff- Dietary	680,401	equal to	680,401	0	O.K.	Pg20 K22..K26	A.	16-Dec	3	Pg3 E9	N/A	1	1
Staff- Maintenance	240,056	equal to	240,056	0	O.K.	Pg20 K27	A.	17	3	Pg3 E14	N/A	6	1
Staff- Housekeeping	240,540	equal to	240,540	0	O.K.	Pg20 K28	A.	18	3	Pg3 E11	N/A	3	1
Staff- Laundry	112,272	equal to	112,272	0	O.K.	Pg20 K29	A.	19	3	Pg3 E12	N/A	4	1
Staff- Administrative	153,484	equal to	153,484	0	O.K.	Pg20 K30..K32	A.	20-22	3	Pg3 E28	N/A	17	1
Staff- Clerical	289,901	equal to	289,901	0	O.K.	Pg20 K33..K34	A.	23+24	3	Pg3 E32	N/A	21	1
Staff- Medical Director	0	equal to		0	O.K.	Pg20 K37	A.	27	3	Pg3 E18	N/A	9	1
Total Salaries And Wages	5,826,206	equal to	5,826,206	0	O.K.	Pg20 K44	A.	34	3	Pg4 E29	N/A	45	1
Dietary Consultant	13,139	< or = to	19,641	-6,502	O.K.	Pg20 X12	B.	35	2	Pg3 G9	N/A	1	3
Medical Director	3,600	< or = to	3,600	0	O.K.	Pg20 X13	B.	36	2	Pg3 G18	N/A	9	3
Consultants & contractors	13,403	< or = to	24,140	-10,737	O.K.	Pg20 X14..X16+	B. & C.	37to39 and 50to5	2	Pg3 G19	N/A	10	3
Activity Consultant	3,792	< or = to	11,697	-7,905	O.K.	Pg20 X21	B.	44	2	Pg3 G21	N/A	11	3
Social Service Consultant	462	< or = to	462	0	O.K.	Pg20 X22	B.	45	2	Pg3 G22	N/A	12	3
Supp. Sched.- Admin. Salar.	153,484	equal to	153,484	0	O.K.	Pg21 I16	A.	N/A	N/A	Pg3 E28	N/A	17	1
Supp. Sched.- Admin. Other		equal to		0	O.K.	Pg21 I24	B.	N/A	N/A	Pg3 G28	N/A	17	3
Supp. Sched.- Prof. Serv.	55,940	equal to	55,940	0	O.K.	Pg21 I41	C.	N/A	N/A	Pg3 G30	N/A	19	3
Supp. Sched.- Benefit/Taxes	1,084,039	equal to	1,084,039	0	O.K.	Pg21 P22	D.	N/A	N/A	Pg3 L33	N/A	22	8
Supp. Sched.- Sched of dues..	61,789	equal to	61,789	0	O.K.	Pg21 V22	F.	N/A	N/A	Pg3 L31	N/A	20	8
Supp. Sched.- Sched. of trav	13,458	equal to	13,458	0	O.K.	Pg21 V41	G.	N/A	N/A	Pg3 L35	N/A	24	8
Gen. Info - Particip. Fees	97,455	equal to	97,455	0	O.K.	Pg23 I38	N/A	11	N/A	Pg4 G25	N/A	42	3
Gen. Info - Employee Meals	0	< or = to		0	O.K.	Pg23 S16	N/A	16	N/A	Pg3 K33	N/A	2 & 22	7
Gen. Info - Employee Meals	0	equal to	0	0	O.K.	Pg23 S16	N/A	16	N/A	Pg21 P12	D.	N/A	N/A
Nurse aide training	0	equal to		0	O.K.	Pg15 U29..U31	B.	3, 4 & 5	4	Pg3 E23	N/A	13	1
Days of medicare provided	2,604	equal to	2,604	0	O.K.	Pg2 AB29	K.	N/A	N/A	Pg2 J30	B.	8	4
Adjustment for related org. costs		equal to	0	#VALUE!	#VALUE!	Pg5 Z18	B.	34	1	Pg6 to Pg 6I Y4(	B.	14	8
Total loan balance	0	equal to	0	0	O.K.	Pg9 L34	A.	15	7	Pg17 V13+V27..	N/A	29+39-41	2
Real estate tax accrual	0	equal to		0	O.K.	Pg10 W15	B.	4	N/A	Pg17 V17	N/A	32	2
Land	128,278	equal to	128,278	0	O.K.	Pg11 T43	A.	3	4	Pg17 K25	N/A	13	2
Building cost	10,435,307	equal to	10,435,307	0	O.K.	Pg12 to 12I L43	B.	36	4	Pg17 K26+K27	N/A	14 & 15	2
Equipment and vehicle cost	2,377,191	equal to	2,377,191	0	O.K.	Pg13 O22+L13	C.& D.	41 + 46	1 + 4	Pg17 K28	N/A	16	2
Accumulated depr.	7,646,885	equal to	7,646,885	0	O.K.	Pg13 Y30	E.	51	2	Pg17 K29	N/A	17	2
End of year equity	33,355,439	equal to	33,355,439	0	O.K.	Pg18 I33	N/A	24	1	Pg17 S39	N/A	47	1
Net income (loss)	-5,371,441	equal to	-5,371,441	0	O.K.	Pg18 I15	N/A	7	1	Pg19 P30	N/A	43	2
Unamortized deferred maint. cost	10,455	equal to	10,455	0	O.K.	Pg22 F31-J31..S	H.	20	3	Pg17 K30	N/A	18	2
Balance Sheet	35,412,255	equal to	35,412,255	0	O.K.	Pg17:H41		25	1	Pg17 S41	N/A	48	1